SMS/MAR (Vol. III, p. 115). This, of course, contradicts her testimony that she believed SMS/MAR was only for charging patients and that, therefore, the time and dosage did not matter. But here she is saying that the *nursing notes* are not accurate as to time of administration, meaning that there is no place where Ms. Dufault believed she had to accurately record her administration of medication as to time and amount.

Again, Ms. Dufault's explanation lacks credibility and compels the obvious conclusion: she was withdrawing additional and unnecessary drugs from the Omnicell for no apparent patient purpose, but for her own purposes.

Incident 3.

This incident occurred from May 21, 2002 to May 30, 2002, and concerned the patient M.G. It is summarized in Hospital Exhibit #9 and documented in Hospital Exhibit #8. On five separate days over this period of time, Ms. Dufault withdrew *double* the dosage ordered by the physician, recorded no waste, and only twice recorded any administration of the medication. All of this left, at a minimum, 8 mg. of Ativan unaccounted for.

Ms. Dufault explains that in some of these instances she recorded an administration of 1 mg. in the nursing notes, but not in the SMS/MAR where it was required to be (Vol II, pp. 168-172). Some of these entries did not show the amount given (Vol. II, p. 170) and in two instances she admits to an overdose by giving 2 mg (Vol. II, pp. 171-172). This means that on three consecutive days, Ms. Dufault "forgot" to have her waste witnessed and recorded and that on two subsequent days she over medicated a patient whom she knew was being given what she described as an "unusual" order for only 1 mg. (Vol. II, 166). Furthermore, the 5/29 entry on the SMS/MAR shows a 1 mg. administration. The grievant's explanation, therefore, is that on